

Bureau of Health Care Quality & Compliance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: NVN3995SNF	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 05/13/2009
NAME OF PROVIDER OR SUPPLIER EVERGREEN GARDNERVILLE HEALTH & REHAB C		STREET ADDRESS, CITY, STATE, ZIP CODE 1573 MATHIAS PKWY GARDNERVILLE, NV 89410		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
Z 000	Initial Comments This Statement of Deficiencies was generated as the result of a complaint investigation under State licensure conducted at your facility on 5/12/09 and finalized on 5/13/09. The survey was conducted using Nevada Administrative Code (NAC) 449, Skilled Nursing Facilities Regulations, adopted by the Nevada State Board of Health. Complaint #NV00021845 was substantiated with deficiencies cited. (See Z 230 and Z 381) The findings and conclusions of any investigation by the Health Division shall not be construed as prohibiting any criminal or civil investigations, actions or other claims for relief that may be available to any party under applicable federal, state, or local laws.	Z 000		
Z230 SS=D	NAC 449.74469 Standards of Care A facility for skilled nursing shall provide to each patient in the facility the services and treatment that are necessary to attain and maintain the patient's highest practicable physical, mental and psychosocial well-being, in accordance with the comprehensive assessment conducted pursuant to NAC 449.74433 and the plan of care developed pursuant to NAC 449.74439. This Regulation is not met as evidenced by: Based on record review, interview, policy review, and review of employee files the facility failed to ensure that a mechanical lift was used in accordance with facility policy to prevent injuries or harm for 1 of 5 residents. (Resident #1) Findings include:	Z230		

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

TITLE

(X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Bureau of Health Care Quality & Compliance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: NVN3995SNF	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 05/13/2009
NAME OF PROVIDER OR SUPPLIER EVERGREEN GARDNERVILLE HEALTH & REHAB C			STREET ADDRESS, CITY, STATE, ZIP CODE 1573 MATHIAS PKWY GARDNERVILLE, NV 89410		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
Z230	<p>Continued From page 1</p> <p>Review of the facility's policy related to use of the mechanical lift revealed a policy titled, "Lifting Machine, Using a Portable, that read: Purpose: The purposes of this procedure are to help lift residents who are too heavy to lift manually and to promote comfort and to maintain good body alignment while the resident is being moved. Key Procedural Points: The portable lift can be used by one CNA if the resident can participate in the lifting procedures. If not two CNA's will be required to perform the procedure. Steps in the Procedure: 11. Remain with the resident until he or she is comfortable and free from any adverse effects from the transfer.</p> <p>Resident #1 was admitted to the facility on 3/17/09 with diagnoses including severe back pain related to a thoracic vertebral compression fracture, chronic obstructive pulmonary disease, obesity, probable right rotator cuff tear, and left hemiplegia due to an old cerebral vascular accident.</p> <p>Resident #1 was interviewed on 5/12/09 at 12:30 PM and reported that she had been left in a mechanical lift and suspended above the bed for ten minutes 5/7/09. A certified nursing assistant (CNA) left the room at 8:00 PM, leaving her unattended in the mechanical lift that was suspended in air until 8:10 PM. She reported that she did not report the incident to any staff. She reported that she told the CNA that she had no business leaving her in the mechanical lift suspended and unattended. She reported that she did not want to get anyone in trouble, but wanted the CNA to become educated on the proper procedure for using the lift. She told the</p>	Z230			

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

Bureau of Health Care Quality & Compliance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: NVN3995SNF	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 05/13/2009
NAME OF PROVIDER OR SUPPLIER EVERGREEN GARDNERVILLE HEALTH & REHAB C			STREET ADDRESS, CITY, STATE, ZIP CODE 1573 MATHIAS PKWY GARDNERVILLE, NV 89410		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
Z230	<p>Continued From page 2</p> <p>CNA that she needed to learn how to use the lift.</p> <p>On 5/12/09 at 11:00 AM, the Director of Nurses (DON) was interviewed. The DON reported that the CNA's are educated about the use of the mechanical lift during the CNA class that is held off site, at a sister facility.</p> <p>Review of the employee files for two CNA's, failed to reveal evidence that they had received training related to the use of the mechanical lift. Review of one CNA's employee file revealed a document titled: "NSBN (Nevada State Board of Nursing) Nursing Assistant Test Results." The document indicated that she had failed the portion of the test pertaining to "Promotion of Health and Safety." No evidence was found that the facility had assessed her educational needs related to health promotion and safety, or provided the training needed to ensure the CNA's competency in providing safe and appropriate patient care.</p> <p>One CNA was interviewed on 5/12/09 at 12:45 PM, and reported that there was no actual training at the facility for CNA's related to the use of the mechanical lift. She reported that CNA's are in-serviced when a problem arises, one on one by the DON, and could not remember the last time that this had occurred.</p> <p>On 5/12/09 at 12:15 PM, the CNA instructor was interviewed and reported that she does go over the proper use of the mechanical lift in the general CNA class. She reported that CNA #1 was in the CNA class held in January and February.</p> <p>Review of the instructor guidelines provided by the CNA instructor, revealed a copy of an instruction guide related to the proper use of a</p>	Z230			

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

Bureau of Health Care Quality & Compliance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: NVN3995SNF	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 05/13/2009
NAME OF PROVIDER OR SUPPLIER EVERGREEN GARDNERVILLE HEALTH & REHAB C			STREET ADDRESS, CITY, STATE, ZIP CODE 1573 MATHIAS PKWY GARDNERVILLE, NV 89410		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
Z230	Continued From page 3 mechanical lift. The instruction section was found to be taken from the periodical, Nursing 2008/March, titled: Smooth patient transfers: Part III; Using a hydraulic lift By Richard Pullen, Jr, RN, EdD. It contained step by step instruction on the use of a mechanical lift, including the following: "Safety First - Never leave a patient unattended in a lift." Severity 2 Scope 1	Z230			
Z381 SS=E	NAC 449.74519 Nursing Assistants 2. A facility for skilled nursing shall ensure that each nursing assistant employed by the facility is able to demonstrate competency in skills and techniques that are necessary to care for the patients in the facility in accordance with each patient's plan of care. This Regulation is not met as evidenced by: Based on record review, interview, policy review, and review of employee files the facility failed to ensure that Certified Nursing Assistants (CNA) were competent to safely use a mechanical lift for 2 of 2 CNA's. (CNA's #1 and #2) Findings include: Resident #1 was admitted to the facility on 3/17/09 with diagnoses including severe back pain related to a thoracic vertebral compression fracture, chronic obstructive pulmonary disease, obesity, probable right rotator cuff tear, and left hemiplegia due to an old cerebral vascular accident. Resident #1 was interviewed on 5/12/09 at 12:30 PM and reported that she was left in a mechanical lift and suspended above the bed for	Z381			

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

Bureau of Health Care Quality & Compliance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: NVN3995SNF	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 05/13/2009
NAME OF PROVIDER OR SUPPLIER EVERGREEN GARDNERVILLE HEALTH & REHAB C			STREET ADDRESS, CITY, STATE, ZIP CODE 1573 MATHIAS PKWY GARDNERVILLE, NV 89410		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
Z381	<p>Continued From page 4</p> <p>ten minutes 5/7/09. A certified nursing assistant (CNA) left the room at 8:00 PM, leaving her unattended and suspended in the air in the mechanical lift air until 8:10 PM.</p> <p>On 5/12/09 at 11:00 AM, the Director of Nurses (DON) was interviewed and reported that the CNA's are educated about the use of the mechanical lift during the CNA class that is held off site, at a sister facility.</p> <p>On 5/12/09 at 12:15 AM, the CNA instructor was interviewed and reported that the proper use of the mechanical lift was included in the general CNA class. She reported that CNA #1 was in the CNA class held in January and February.</p> <p>Review of the instructor guidelines provided by the CNA instructor revealed a copy of an instruction guide related to the proper use of a mechanical lift. The instruction section was found to be taken from the periodical, Nursing 2008/March, titled: Smooth patient transfers: Part III; Using a hydraulic lift By Richard Pullen, Jr, RN, EdD. It contained step by step instruction on the use of a mechanical lift, including the following: "Safety First - Never leave a patient unattended in a lift."</p> <p>Review of the employee files for CNA #1 and CNA #2, failed to reveal evidence that they had received training related to the use of the mechanical lift. There was no competency evaluation found for either CNA #1 or CNA #2. CNA #1 had been hired by the facility in 2/09 and CNA #2 had been employed at the facility since 2006.</p> <p>Review of CNA #1's employee file revealed a document titled: "NSBN (Nevada State Board of</p>	Z381			

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

Bureau of Health Care Quality & Compliance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: NVN3995SNF	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 05/13/2009
NAME OF PROVIDER OR SUPPLIER EVERGREEN GARDNERVILLE HEALTH & REHAB C		STREET ADDRESS, CITY, STATE, ZIP CODE 1573 MATHIAS PKWY GARDNERVILLE, NV 89410		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
Z381	<p>Continued From page 5</p> <p>Nursing) Nursing Assistant Test Results" The document revealed that CNA #1 had failed the portion of the test pertaining to "Promotion of Health and Safety." No evidence was found that the facility had assessed her educational needs related to health promotion and safety or provided the training to ensure the CNA #1's competency in providing safe and appropriate patient care.</p> <p>On 5/12/09 at 12:00 PM, the Administrator was interviewed and reported that the CNA's are not evaluated for competency with the use of equipment or the other general nursing assistant functions. She reported that the newly hired CNA's are paired with an experienced CNA for a couple of days. He further reported that there was no way to evaluate whether or not this was an effective means of training new CNA's.</p> <p>CNA #2 was interviewed on 5/12/09 at 12:45 PM, and reported that there was no actual training at the facility for CNA's related to the use of the mechanical lift. She reported that CNA's are in serviced when a problem arises, one on one by the DON, and could not remember the last time that this had occurred.</p> <p>Severity 2 Scope 2</p>	Z381		

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.